Dec 29, 2008

Honorable Robert D. Drain
United States Bankruptcy Court
Southern District of New York
One Bowling Green Room 610
New York, New York 10004

Dear Honorable Robert D. Drain

Enclosed are copies of the documents I did not add to previous letter dated Dec 3, 2008. I hope these documents and information is added to my claim.
Let not Thank You for Reading, Receiving them.

Sincerely,
M. Stanley Cartee

PS. I also called Kurtzman Carson Consultants and spoke to Jason he called me back and spoke to him finally, but he stated my claim is not a claim due to my Atty Damon in Cincinnati not a file of my claim. I want get any information.
Stanley Cartee

1 of 2

Dec 3, 2008

Honorable Robert D. Drain
United States Bankruptcy Court
Southern District of New York
One Bowling Green, Room 610
New York, New York 10004

Dear Honorable Robert D. Drain

I Sharyl Yvette Carter, enclosing copies of documents concerning my previous Attorney Todd Kibre, + Baron + Associates letters, copies from, of concerning my Workers Compensation Rights, claims. As I continue being mislead, misrepresentation, delay tactic, etc. Atty Todd time withdraw my claim, until it expire, I fired him, then Baron + Associates contacted me, I fired that firm, then Baron + Associates had me sign a form giving them access to my Social Security file which again I was misled, misrepresented, they never contacted my doctors, the claim was dismissed, 3/08, I was notified 10/24/08 after my Social Security Hearing 8/, I fired Baron + Associates then hired Michael Kearns who can not doing nothing at this point.

I don't know if my Workers Compensation is added in my claim in error court, I tried several times to contact Delphi Attorney Kurtzman Carson Consultants, LLC, I was directed to an recording several times, I left several messages. In the documents I received on Oct 6, 2008, I read failure of the Debors to pay their Workers Compensation obligations suppose to Result in a claim down, the Debtors are authorized to pay all amounts Related in Workers Compensations claims. I do not know if the amounts are

2 of 2

included in my claim.
Also Honorable Robert D. Drain I did not sign any papers giving up any of my rights. I also hope that my other Attorney Geoffrey Damon gave up all my notes including the last one dated 5/06 through 12/15/06
Thank You.

Sincerely
M. Sharyl J. Carter

P.S. There was my 1st Attorney who handled this claim in Dayton Ohio, who I had to report to the Bar Association on misrepresentation, and lied document that took 1½ yrs to be denied.

Sincerely
M. Sharyl J. Carter

Oct 21, 2008

Bevan + Associates L.P.A Inc
10826 Northfield Road
Northfield Ohio 44067

Dear Thomas W. Bevan + Patrick M. Walsh.

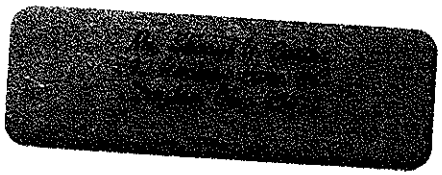
I Sharyl R. Carter Reside at 92 Wookery Lane Clayton Ohio 45315, (937) 832-8872 would like to dismiss 2/our office Bevan + Associates LPA Inc as Representing me on my case for Workers Compensation, case no of Dc-988317.

My Reason 2/our office sent me an letter Sept 4, 2008 I responded, Another letter issue from Thomas Bevan Requesting my Signature for Request of Social Security statement. All this and 2/our office never contacted my doctors at all, 2/ou called me once never Returned my call. Also upon on Oct 2008 Almost 2/ear I haven't heard anything else from 2/our office, be have I heard on Hearing on my Claim of Workers Compensation Case no Dc-988317.

Again I am dismissing 2/ou and 2/our Company Bevan + Associates LPA Inc from Representing me. As stated I'm firing 2/ou + 2/our Company person Representing me in my Workers Compensation Claim.

Enclosed is a copy of 2/our Recent letter dated Oct 20, 2008

Sincerely,




Public Disclosure Room, Room N1513
Employee Benefits Security Admin. US Dept of Labor
200 Constitution Avenue, N.W.
Washington, DC. 20210

Dec 30, 2008

Public Disclosure Room, Rm N1513
Employee Benefits Sec. Admin, U.S. Dept of Labor
200 Constitution Avenue, NW.
Washington, D.C. 20210

To Whom It may Concern.

Enclosed are papers I received from Delphi Corporation P.O. Box 925, Tifton, GA 31793. I would like to know the amount of my claim against Delphi in Bankruptcy Court. I have tried several times to call Delphi Attorney Kurtzman Carson Consultants, but I get an answering machine, I leave a message, no return call. Hopefully you can help me. Thank You.

Sincerely,
M. [illegible] Lara

# Ohio Bureau of Workers Compensation Detail

Access: **REPRESENTATIVE**
Selection: **SSN SEARCH**
Sub Selection: **CLAIM STATUS**
SSN:

Date/Time Searched: **10/28/2008 02:39 PM**

Ohio

DISCONNECT

## Claim Status

| | | | | | |
|---|---|---|---|---|---|
| Claim # | **06-888317** | Claim Status | **DISMISSED** | Claim Type | **LT-ACC-SI-COV** |
| Injured Worker | **CARTER, SHARYL Y** | | | Injury Date | **12-15-2006** |
| Filing Date | **01-10-2007** | Statute of Lim. | **12-16-2011** | Change Over | |
| Status | **ACTIVE** | Status Date | **12-15-2006** | Handicap Pct. | **0.0** |
| Last Hearing | | Last Medical Paid | | Last Indemnity Paid | |
| Tot Amount Paid | **$0.00** | Tot Medical Paid | **$0.00** | Tot Indemnity Paid | **$0.00** |
| Provider Contact | | Inj Worker Contact | | Employer Contact | |
| Medical Settled | | Compensation Settled | | Determination | **03-05-2007** |
| Last Updated | **11-05-2007** | MMI Date | | | |

Selection Menu | SSN Search
Injured Worker | Injury Status | Payment Plan

# Ohio Bureau of Workers Compensation Detail

Access: **REPRESENTATIVE**
Selection: **SSN SEARCH**
Sub Selection: **CLAIM STATUS**
SSN:

Date/Time Searched: **10/28/2008 02:39 PM**

C

DISCONNECT

## Claim Status

| | | | | | |
|---|---|---|---|---|---|
| Claim # | 04-826088 | Claim Status | DISALLOWED | Claim Type | LT-ACC-SI-COV |
| Injured Worker | CARTER, SHARYL Y | | | Injury Date | 04-27-2004 |
| Filing Date | 05-12-2004 | Statute of Lim. | 04-27-2014 | Change Over | 06-24-2004 |
| Status | ACTIVE | Status Date | 04-27-2004 | Handicap Pct. | 0.0 |
| Last Hearing | | Last Medical Paid | | Last Indemnity Paid | |
| Tot Amount Paid | $0.00 | Tot Medical Paid | $0.00 | Tot Indemnity Paid | $0.00 |
| Provider Contact | | Inj Worker Contact | | Employer Contact | |
| Medical Settled | | Compensation Settled | | Determination | 06-24-2004 |
| Last Updated | 09-14-2004 | MMI Date | | | |

Selection Menu | SSN Search
Injured Worker | Injury Status | Payment Plan

OPEN online

# Ohio Bureau of Workers Compensation Detail

Access: **REPRESENTATIVE**
Selection: **SSN SEARCH**
Sub Selection: **CLAIM STATUS**
SSN:

Date/Time Searched: **10/28/2008 02:40 PM**

Oh

DISCONNECT

## Claim Status

| | | | | | |
|---|---|---|---|---|---|
| Claim # | 98-801409 | Claim Status | DISALLOWED | Claim Type | MO-ACC-SI-COV |
| Injured Worker | CARTER, SHARYL Y | | | Injury Date | 03-01-1998 |
| Filing Date | 05-19-2003 | Statute of Lim. | 03-01-2004 | Change Over | |
| Status | ACTIVE | Status Date | 03-01-1998 | Handicap Pct. | 0.0 |
| Last Hearing | | Last Medical Paid | | Last Indemnity Paid | |
| Tot Amount Paid | $0.00 | Tot Medical Paid | $0.00 | Tot Indemnity Paid | $0.00 |
| Provider Contact | | Inj Worker Contact | | Employer Contact | |
| Medical Settled | | Compensation Settled | | Determination | 06-30-2003 |
| Last Updated | 04-28-2006 | MMI Date | | | |

Selection Menu | SSN Search | Injured Worker | Injury Status | Payment Plan

# Ohio Bureau of Workers Compensation Detail

Access: **REPRESENTATIVE**
Selection: **SSN SEARCH**
SSN:

Date/Time Searched: **10/28/2008 02:39 PM**

Ol... Status: CONNECTED ☒ DISCONNECT

## Social Security Search

Click the circle next to the Claim Number and then click on the appropriate Sub Request.

| | CLAIM # | INJURED WORKER | DATE OF INJURY | ARCHIVED | SOURCE | STATUS |
|---|---|---|---|---|---|---|
| ○ | 98-801409 | SHARYL Y CARTER | 03/01/1998 | | | |
| ○ | 06-888317 | SHARYL Y CARTER | 12/15/2006 | | | |
| ○ | 04-826088 | SHARYL Y CARTER | 04/27/2004 | | | |

Selection Menu

Claim Location | Claim Status | Injured Worker

August 30, 2007

Atty Todd B. Kirk & Associates
556 Wards Corner Road Suite 102
Loveland, Ohio 45140

Dear Mr. Todd Kirk

I Sharyl L. Carter reside at 92 Wesley Lane # D, Dayton OH 45415, my phone No# (937) 890-0176 Cell (937) 302-8078.

This letter is concerning my Workers Compensation Claim-Case in Dayton Ohio. I want to Thank You Very much in Representing me as my Attorney-Lawyer. You and your associates did an excellent job, I appreciated all that you have done. I am Dismissing You as my Attorney in this matter, due to personal reasons. Again I want to Thank You & Associates for a job well done.

I would appreciate if you can send me All Copies and documents in this matter concerning me, Also Response from Delphi.

Sincerely
Ms. Sharyl L. Carter

# BEVAN & ASSOCIATES LPA, INC.

Bevan Professional Building 10360 Northfield Rd. Northfield, Ohio 44067

THOMAS W. BEVAN
CHRISTOPHER J. STEFANCIK
DAVID S. BATES
DWIGHT P. MOTSCO
PATRICK M. WALSH
JOHN D. MISMAS
ANGELA HARDWAY
CINDY L. KOBAL

Toll-Free Phone: (877) 873-2879
Fax: (330) 467-4493
Akron: (330) 650-0088
Cleveland: (330) 467-8571

of Counsel
KEITH D. BEVAN

SHARYL CARTER
92 WOOLERY LN APT C
DAYTON, OH 45415

Dear Client:

Thank you for giving us the opportunity to represent you on your workers' compensation claim(s). The purpose of this letter is to explain what you may expect in the next few months.

Your file has been transferred to our main office for further processing. Our staff will review your file to make sure that your claim is allowed for the proper conditions and that any benefits that you are owed are properly paid. If you have any problems with your claim(s), please notify our office immediately.

Furthermore, 26 weeks after your date of injury or 26 weeks after you returned to work from your injury, we will file an application for permanent partial disability. This will enable us to pursue a cash award for your injury.

The amount of your cash award will depend, in part, on the wages that you earned in the year prior to your injury. Accordingly, to prevent any delays in payment on your claim, it is necessary that we submit wage information to the BWC as soon as possible. I have enclosed a Social Security release form that will enable us to get your wage information from the Social Security office. We will submit your wage information to the BWC. Please sign this form where indicated and return it to us in the enclosed envelope. ***PLEASE PROVIDE THE INFORMATION ONLY IN THE AREAS ON THE FORM INDICATED BY THE ARROW! THIS INCLUDES ONLY BOXES 1 THROUGH 5 AND BE SURE TO SIGN THE FORM WHERE INDICATED!***

If you have any questions regarding your claim(s), please call our main office at the above-stated numbers or toll-free at 1-877-873-2879.

Sincerely,

Thomas W. Bevan

Enclosure

Form Approved
OMB No. 0960-0446 SP

# Request for *Social Security Statement*

☐ Please check this box if you want to get your *Statement* in Spanish instead of English.

Please print or type your answers. When you have completed the form, fold it and mail it to us. (If you prefer to send your request using the Internet, contact us at *www.socialsecurity.gov)*

1. Name shown on your Social Security card:

SHARYL Y
First Name Middle Initial

CARTER
Last Name Only

on your

3

3. Your date of birth (Mo.-Day-Yr.)

09-01-1964

4. Other Social Security numbers you have used:

☐☐☐-☐☐-☐☐☐☐
☐☐☐-☐☐-☐☐☐☐

5. Your Sex: ☐ Male ☒ Female

**For items 6 and 8 show only earnings covered by Social Security.** Do NOT include wages from state, local or federal government employment that are NOT covered for Social Security or that are covered ONLY by Medicare.

6. Show your actual earnings (wages and/or net self-employment income) for last year and your estimated earnings for this year.

A. Last year's actual earnings: *(Dollars Only)*
$ ☐☐☐,☐☐☐.00

B. This year's estimated earnings: *(Dollars Only)*
$ ☐☐☐,☐☐☐.00

7. Show the age at which you plan to stop working:
☐☐ *(Show only one age)*

8. Below, show the average yearly amount (not your total future lifetime earnings) that you think you will earn between now and when you plan to stop working. Include performance or scheduled pay increases or bonuses, but not cost-of-living increases.

If you expect to earn significantly more or less in the future due to promotions, job changes, part-time work, or an absence from the work force, enter the amount that most closely reflects your future average yearly earnings.

If you don't expect any significant changes, show the same amount you are earning now (the amount in 6B).

Future average yearly earings: *(Dollars Only)*
$ ☐☐☐,☐☐☐.00

9. Do you want us to send the *Statement:*
- To you? Enter your name and mailing address.
- To someone else (your accountant, pension plan, etc.)? Enter your name with "c/o" and the name and address of that person or organization.

Bevan & Associates LPA, Inc.
61 W. Aurora Rd.
Northfield, OH 44067

**NOTICE:**
I am asking for information about my own Social Security record or the record of a person I am authorized to represent. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I authorize you to use a contractor to send the *Social Security Statement* to the person and address in item 9.

→ Sharyl J. Carter
**Please sign your name (Do Not Print)**

Date (Area Code) Daytime Telephone No.

Form SSA-7004-SM (10-2004) EF (10-2004)
Destroy prior editions.

Printed on recycled paper

# BEVAN & ASSOCIATES LPA, INC.

Bevan Professional Building 10360 Northfield Road Northfield, Ohio 44067

THOMAS W. BEVAN
CHRISTOPHER J. STEFANCIK
DAVID S. BATES
DWIGHT P. MOTSCO
PATRICK M. WALSH
JOHN D. MISMAS
ANGELA M. HARDWAY
CINDY L. KOBAL
JESSICA M. BACON

Akron (330) 650-0088
Cleveland (330) 467-8571
Fax (330) 467-4493
of Counsel
KEITH D. BEVAN

October 20, 2008

Ms. Sharyl Y. Carter
92 Woolery Lane
Apartment C
Dayton Ohio 45415

Re: Claim No. 06-888317
D.O.I. 12-15-2006

Dear Ms. Carter:

Thank you for allowing me to review your Workers' Compensation Claim No. 06-888317. I have examined the documentation in the file including the orders denying your application for workers' compensation benefits. Unfortunately I do not see any opportunity to reverse this denial.

Again, I appreciate you giving me the chance to review this claim and am sorry I could not be of assistance in this case. I would advise that if you are injured on the job in the future to contact an attorney immediately. Proper application preparation and representation at initial hearings is often crucial to obtaining a positive result.

Please feel free to call the office if you have any further questions.

Sincerely,

Christopher J. Stefancik
Attorney at Law for
Bevan & Associates

CJS/sjr

BWC
Better Workers' Compensation
Built with you in mind.

# APPLICATION FOR DETERMINATION OF PERCENTAGE OF PERMANENT PARTIAL DISABILITY or INCREASE OF PERMANENT PARTIAL DISABILITY

INSTRUCTIONS:
- Please use a typewriter or ballpoint pen and press firmly to complete this form.
- You or your representative must sign this form before submission.
- You must submit three copies and retain one copy for your records.
- If assistance is needed you may contact your local BWC customer service office.

Claim number: 06-888317

**Application for:**

☐ Determination of the initial percentage of permanent partial disability (%PPD)

☐ Determination in the %PPD for a newly allowed condition in this claim (no new medical required)

☐ Increase in the %PPD – **I believe that the percentage of permanent partial disability has increased over the percentage previously determined. I have attached three copies of the medical report from my doctor to support this application. Medical reports attached are accompanied by evidence of new and changed circumstances.**

## PART A – INJURED WORKER INFORMATION

| | | | |
|---|---|---|---|
| Injured worker name: SHARYL CARTER | | | Date of injury: 12/15/2007 |
| Address: 92 WOOLERY LN APT C | | | |
| City: DAYTON | | OH | 9-digit ZIP Code: 45415 |
| County: MONTGOMERY | Work telephone number: ( ) | Home telephone number: ( ) 937-890-0176 | |

## PART B – APPLICATION INFORMATION

| | | | |
|---|---|---|---|
| Employer at the time of injury | | Telephone number: ( ) | |
| Address | | | |
| City | | State | 9-digit ZIP Code |

Describe the disability which you now consider to be permanent as a result of your injury or occupational disease. How does this injury or occupational disease affect your activities of daily living? (specify parts of the body affected)

Other workers' compensation claim numbers and the nature of each injury or occupational disease are listed below.

| CLAIM NUMBER | ALLOWED CONDITION | CLAIM NUMBER | ALLOWED CONDITION |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

## PART C – AUTHORIZATION

| | |
|---|---|
| Name of injured worker representative (if represented) (please print or type): Bevan and Associates LPA, Inc. | REP I.D. number: 217393-91 |
| Signature of injured worker / injured worker representative (if represented) | Date |

**Thereby authorize the BWC/employer to forward any monetary award generated by this application to the attorney indicated above for disbursement to me.**

| | |
|---|---|
| Signature of injured worker | Date |

## BWC USE ONLY

| | |
|---|---|
| Copy mailed to: ☐ Employer ☐ Employer representative | Date mailed |

Distribution: Original–Claim file Copies–as needed

BWC-1214 (C-92 and C-92-A combined) (Rev. 12/4/2001)
C-92

# ATTORNEY FEE AGREEMENT

I, SHARYL CARTER hereby retain(s) BEVAN & ASSOCIATES, LPA, INC. (Attorneys) to act as my attorneys to pursue benefits in my workers' compensation claim(s).

As compensation for services, Client agrees to pay his Attorneys from the proceeds of recovery, a fee equal to one-third (1/3) of the accrued portion of temporary total disability benefits, any permanent partial disability awards, amputation awards, wage loss awards, settlement or other monetary award. **In the event that no monetary award is secured for the client, no attorney fee is owed.**

In the event that ATTORNEYS incur costs procuring medical records or reports, ATTORNEYS may advance the cost of said records and reports and recoup that cost from future awards. In the event that ATTORNEYS do not secure a monetary award for client, ATTORNEYS shall not seek reimbursement for costs directly from client.

BEVAN & ASSOCIATES, LPA, Inc. shall, from time to time, retain additional counsel for purposes of handling administrative hearings. In such event, there shall be no additional costs to Client.

Date

Client Signature

Print Client Name

Bevan & Associates, LPA, Inc.
10360 Northfield Road
Northfield, Ohio 44067

BWC
Better Workers' Compensation
Built with you in mind.

# Authorization to Release Medical Information

*This form can be obtained online at **www.ohiobwc.com***

**INSTRUCTIONS:**
- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form and send to the service office where your claim is located or to your self-insured employer.

| Injured worker name (first, M.I., last) | | Date of injury | Claim number |
|---|---|---|---|
| SHARYL CARTER | | 12/15/2007 | 06-888317 |
| **Address** | **City** | **State** | **9-digit ZIP code** |
| 92 WOOLERY LN APT C | DAYTON | OH | 45415 |
| **Employer name** | **Employer MCO or QHP** | | |
| | | | |

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the following providers (persons or facilities) that attend, treat or examine me (list providers here)

_____

_____ ,to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other

_____

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC), the above-named employer, the employer's managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. However, I understand I have the right to revoke this authorization at any time, but my revocation must be submitted in writing and filed with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include, but are not limited to, the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer.
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

| Injured worker (or guardian or personal representative) signature | Date |
|---|---|
| Sharyl A. Carter | |

If signed by the injured worker's guardian or personal representative, provide here a description of the guardian or personal representative's authority to sign on behalf of the injured worker_____

_____

BWC-1224 (Rev. 3/24/2003)
**C-101**

# Injured Worker Authorized Representative

**INSTRUCTIONS:**
- This form must be completed in its entirety by the Injured Worker and Representative and filed with the Ohio Bureau of Workers' Compensation (BWC).
- A valid BWC Representative I.D. number is required.
- To obtain a valid Representative I.D. number contact the Central Office, Customer Assistance Desk at 614.466.1958 or 614.466.1563 or inquire at any BWC Customer Service Office Information desk.

| Injured worker name | | Claim number |
|---|---|---|
| SHARYL CARTER | | 06-888317 |
| **Injured worker address** | | **City, State, ZIP Code** |
| 92 WOOLERY LN APT C | | DAYTON, OH 45415 |
| **Date of injury** | **Phone number** | **Social Security Number** |
| 12/15/2007 | 937-890-0176 | |
| **Employer name at date of injury** | | |

**REPRESENTATIVE**

| Representative name | Representative I.D. number | |
|---|---|---|
| Bevan and Associates LPA, Inc. | 217393-91 | |
| **Address** | **Federal tax number or Social Security Number** | |
| 10360 Northfield Rd. | 34-1815438 | |
| **City, State, ZIP Code** | **Telephone number** | **Fax number** |
| Northfield, OH 44067 | 330-650-0088 | 330-467-4493 |

**AUTHORIZATION**

*I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Industrial Commission of Ohio. This authorization also entitles this Representative to automatically receive correspondence generated in the above claim file.*

X Sharyl Y. Carter

**Signature of injured worker** | **Date of Authorization**

BWC-6102 (6/15/2004)
R-2

BWC
Better Workers' Compensation
Built with you in mind.

# Authorization to Receive Workers' Compensation Check

This form can be obtained online at **ohiobwc.com**

| Injured worker's name | Claim number |
|---|---|
| SHARYL CARTER | 06-888317 |

| Attorney's name | I.D. number |
|---|---|
| Bevan and Associates LPA, Inc. | 217393-91 |

**Instructions for completion**

- This form must be completed in its entirety including the correct claim number.
- Any authorization not completed in its entirety, altered but not initialed by the party altering the form, or not filed within the proper time periods specified **will not be honored.**
- The award must be specified.
- An authorization must be filed for every claim for which an award is to be made.

**Time limits** for filing are as follows:

1) On any compensation paid pursuant to the filing of a C-92, the authorization must be filed with the application, with the agreement of permanent partial disability, with election, with the Industrial Commission of Ohio (IC) at hearing, or after hearing but prior to the date of mailing of the order.
2) IC order – prior to hearing, or at the hearing.
3) Any order from which there is no appeal or objection period – at the hearing or with application.

I hereby authorize and direct BWC to mail directly to my attorney the compensation check in the above numbered claim for the accrued portion of my award as specified - *(Check **only one** block)*

- ☐ 1. Temporary total – BWC order _____
- ☐ 2. Temporary total – IC hearing dated _____
- ☐ 3. Impairment of earning capacity
- ☐ 4. Wage loss
- ☐ 5. % Permanent partial
- ☐ 6. Permanent partial; scheduled losses
- ☐ 7. Permanent total – IC order dated _____
- ☐ 8. Lump sum settlement
- ☐ 9. Death award – BWC order _____
- ☐ 10. Death award – IC hearing dated _____
- ☐ 11. Change of occupation
- ☐ 12. Facial disfigurement
- ☐ 13. VSSR – Violation of specific safety requirements
- ☐ 14. Application or Motion dated _____

This authorization is with the limitation that my attorney does not have the authority to cash or endorse this check on my behalf.

Authorizations will be honored for 18 months from the date executed. An authorization timely filed will be honored for any hearing, appeal, or reconsideration on the original issue. An authorization shall not continue in effect after said award or awards have been paid.

| Injured worker's signature | Date |
|---|---|
| Sharyl J. Carter | |

BWC USE

This authorization is not honored by BWC because:

☐ It was not timely filed ☐ It was not properly completed
☐ Other _____

| Claims representative's signature | Office | Date |
|---|---|---|
| | | |

BWC-1360 (Rev. 11/03/2003)
**C-230**

# Ohio Bureau of Workers Compensation


| Return to Selection Menu | Record Help |
|---|---|

Access : **Representative**

Date Searched : **10/24/2007**

Selection : **SSN Search**

Sub Selection : **Injury Status**

Claim Number : **06-888317**

---

**To disconnect from the Ohio BWC system, please click the log-off button.**

Log-off BWC

## Injury Status

Claim Number : **06-888317** Claim Status : **DISMISSED** Claim Type : **LT-ACC-SI-COV**

Injured Worker : **CARTER, SHARYL Y** Injury Date : **12-15-2006**

Description : **TRUNK INJURY NOS**

ICD Nbr : **959.19** Primary Loc : Site :

Application : **HEARING** Status Date : **04-02-2007** Status : **DISMISSED**

(F2) Selection Menu | (F3) Return to SSN Search

(F4) Medical Prior Authorization | (F5) Injury Worker | (F6) Claim Provider



Contact Customer Support for assistance at 1-800-366-0106

BEVAN & ASSOCIATES LPA, INC.
*Attorneys at Law*
Bevan Professional Building
10360 Northfield Road
Northfield, Ohio 44067


Sharyl Carter
92 Woodbury Dr Apt C
Dayton, Oh 45415

45415+1725 C026

**BEVAN & ASSOCIATES LPA, INC.**

Bevan Professional Building 10360 Northfield Road Northfield, Ohio 44067

THOMAS W. BEVAN
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of Counsel
KEITH D. BEVAN

SHARYL CARTER
92 WOOLERY LN APT C
DAYTON, OH 45415

Dear Client:

Pursuant to your recent telephone conversation with our office, enclosed please find the following forms:

1. R-2 Card: Injured Worker Authorized Representative
2. C-230 form: Authorization to Receive Workers' Compensation Check
3. Attorney Fee Agreement
4. Authorization to Disclose Health Information
5. C-92 form: Application for Determination of Percent of Permanent Partial Disability

Please sign each of these forms where highlighted and/or marked with an "X". *PLEASE DO NOT DATE OR COMPLETE ANY INFORMATION ON THE FORMS,* as we will prepare them at a later date.

Also, note that our fee agreement states that we only get paid if we generate money for you. Many issues in workers' compensation, such as allowance or payment of bill issues, do not generate compensation for you. We do not charge a fee for these services.

If you have any questions about your claim, please call us toll-free at 1866-926-4440. **Please return the signed forms within two (2) weeks so that we may begin processing your claim.**

Sincerely,

Law office of Bevan & Associates LPA
Workers' Compensation Department

BWC
Better Workers' Compensation
Built with you in mind.

# APPLICATION FOR DETERMINATION OF PERCENTAGE OF PERMANENT PARTIAL DISABILITY or INCREASE OF PERMANENT PARTIAL DISABILITY

INSTRUCTIONS:
- Please use a typewriter or ballpoint pen and press firmly to complete this form.
- You or your representative must sign this form before submission.
- You must submit three copies and retain one copy for your records.
- If assistance is needed you may contact your local BWC customer service office.

Claim number

**Application for:**

☐ Determination of the initial percentage of permanent partial disability (%PPD)

☐ Determination in the %PPD for a newly allowed condition in this claim (no new medical required)

☐ Increase in the %PPD – **I believe that the percentage of permanent partial disability has increased over the percentage previously determined. I have attached three copies of the medical report from my doctor to support this application. Medical reports attached are accompanied by evidence of new and changed circumstances.**

## PART A – INJURED WORKER INFORMATION

| Injured worker name | Social Security Number | Date of injury |
|---|---|---|
| SHARYL CARTER | 081-58-9353 | |

| Address | | | |
|---|---|---|---|
| 92 WOOLERY LN APT C | | | |
| City: DAYTON | | State: OH | 9-digit ZIP Code: 45415 |
| County: MONTGOMERY | Work telephone number: ( ) | Home telephone number: ( ) 937-890-0176 | |

## PART B – APPLICATION INFORMATION

| Employer at the time of injury | Telephone number ( ) |
|---|---|
| Address | |
| City | State / 9-digit ZIP Code |

Describe the disability which you now consider to be permanent as a result of your injury or occupational disease. How does this injury or occupational disease affect your activities of daily living? (specify parts of the body affected)

Other workers' compensation claim numbers and the nature of each injury or occupational disease are listed below.

| CLAIM NUMBER | ALLOWED CONDITION | CLAIM NUMBER | ALLOWED CONDITION |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

## PART C – AUTHORIZATION

| Name of injured worker representative (if represented) (please print or type) | REP I.D. number |
|---|---|
| Bevan and Associates LPA, Inc. | 217393-91 |

| Signature of injured worker / injured worker representative (if represented) | Date |
|---|---|
| Sharyl L. Carter | |

**I hereby authorize the BWC/employer to forward any monetary award generated by this application to the attorney indicated above for disbursement to me.**

| Signature of injured worker | Date |
|---|---|
| Sharyl L Carter | |

## BWC USE ONLY

| Copy mailed to: ☐ Employer ☐ Employer representative | Date mailed |
|---|---|

**Distribution: Original–Claim file Copies–as needed**

# ATTORNEY FEE AGREEMENT

I, SHARYL CARTER hereby retain(s) BEVAN & ASSOCIATES, LPA, INC. (Attorneys) to act as my attorneys to pursue benefits in my workers' compensation claim(s).

As compensation for services, Client agrees to pay his Attorneys from the proceeds of recovery, a fee equal to one-third (1/3) of the accrued portion of temporary total disability benefits, any permanent partial disability awards, amputation awards, wage loss awards, settlement or other monetary award. **In the event that no monetary award is secured for the client, no attorney fee is owed.**

In the event that ATTORNEYS incur costs procuring medical records or reports, ATTORNEYS may advance the cost of said records and reports and recoup that cost from future awards. In the event that ATTORNEYS do not secure a monetary award for client, ATTORNEYS shall not seek reimbursement for costs directly from client.

BEVAN & ASSOCIATES, LPA, Inc. shall, from time to time, retain additional counsel for purposes of handling administrative hearings. In such event, there shall be no additional costs to Client.

Date

Client Signature

Print Client Name

Bevan & Associates, LPA, Inc.
10360 Northfield Road
Northfield, Ohio 44067

BWC
Better Workers' Compensation
Built with you in mind.

# Authorization to Release Medical Information

*This form can be obtained online at **www.ohiobwc.com***

**INSTRUCTIONS:**
- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form and send to the service office where your claim is located or to your self-insured employer.

| Injured worker name (first, M.I., last) | Date of injury | Claim number |
|---|---|---|
| SHARYL CARTER | | |

| Address | City | State | 9-digit ZIP code |
|---|---|---|---|
| 92 WOOLERY LN APT C | DAYTON | OH | 45415 |

| Employer name | Employer MCO or QHP |
|---|---|
| | |

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the following providers (persons or facilities) that attend, treat or examine me (list providers here)

_____

_____ ,to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other

_____

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC), the above-named employer, the employer's managed care organization (MCO) or qualified health plan (QHP) and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. However, I understand I have the right to revoke this authorization at any time, but my revocation must be submitted in writing and filed with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include, but are not limited to, the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer.
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

| Injured worker (or guardian or personal representative) signature | Date |
|---|---|
| | |

If signed by the injured worker's guardian or personal representative, provide here a description of the guardian or personal representative's authority to sign on behalf of the injured worker_____

_____ .

BWC-1224 (Rev. 3/24/2003)
**C-101**

# Injured Worker Authorized Representative

**INSTRUCTIONS:**
- This form must be completed in its entirety by the Injured Worker and Representative and filed with the Ohio Bureau of Workers' Compensation (BWC).
- A valid BWC Representative I.D. number is required.
- To obtain a valid Representative I.D. number contact the Central Office, Customer Assistance Desk at 614.466.1958 or 614.466.1563 or inquire at any BWC Customer Service Office Information desk.

| Injured worker name | | Claim number |
|---|---|---|
| SHARYL CARTER | | |
| **Injured worker address** | | **City, State, ZIP Code** |
| 92 WOOLERY LN APT C | | DAYTON, OH 45415 |
| **Date of injury** | **Phone number** | **Social Security Number** |
| | 937-890-0176 | |
| **Employer name at date of injury** | | |
| | | |

**REPRESENTATIVE**

| Representative name | | Representative I.D. number |
|---|---|---|
| Bevan and Associates LPA, Inc. | | 217393-91 |
| **Address** | | **Federal tax number or Social Security Number** |
| 10360 Northfield Rd. | | 34-1815438 |
| **City, State, ZIP Code** | **Telephone number** | **Fax number** |
| Northfield, OH 44067 | 330-650-0088 | 330-467-4493 |

**AUTHORIZATION**

*I hereby authorize the above representative to represent me in the above claim before the Ohio Bureau of Workers' Compensation and the Industrial Commission of Ohio. This authorization also entitles this Representative to automatically receive correspondence generated in the above claim file.*

X Sharyl K. Carter

**Signature of injured worker** | **Date of Authorization**

BWC-6102 (6/15/2004)
R-2

# Authorization to Receive Workers' Compensation Check

This form can be obtained online at ohiobwc.com

| Injured worker's name | Claim number |
|---|---|
| SHARYL CARTER | |

| Attorney's name | I.D. number |
|---|---|
| Bevan and Associates LPA, Inc. | 217393-91 |

**Instructions for completion**

- This form must be completed in its entirety including the correct claim number.
- Any authorization not completed in its entirety, altered but not initialed by the party altering the form, or not filed within the proper time periods specified **will not be honored**.
- The award must be specified.
- An authorization must be filed for every claim for which an award is to be made.

**Time limits** for filing are as follows:

1) On any compensation paid pursuant to the filing of a C-92, the authorization must be filed with the application, with the agreement of permanent partial disability, with election, with the Industrial Commission of Ohio (IC) at hearing, or after hearing but prior to the date of mailing of the order.
2) IC order – prior to hearing, or at the hearing.
3) Any order from which there is no appeal or objection period – at the hearing or with application.

I hereby authorize and direct BWC to mail directly to my attorney the compensation check in the above numbered claim for the accrued portion of my award as specified - *(Check **only one** block)*

- ☐ 1. Temporary total – BWC order _____
- ☐ 2. Temporary total – IC hearing dated _____
- ☐ 3. Impairment of earning capacity
- ☐ 4. Wage loss
- ☐ 5. % Permanent partial
- ☐ 6. Permanent partial; scheduled losses
- ☐ 7. Permanent total – IC order dated _____
- ☐ 8. Lump sum settlement
- ☐ 9. Death award – BWC order _____
- ☐ 10. Death award – IC hearing dated _____
- ☐ 11. Change of occupation
- ☐ 12. Facial disfigurement
- ☐ 13. VSSR – Violation of specific safety requirements
- ☐ 14. Application or Motion dated _____

This authorization is with the limitation that my attorney does not have the authority to cash or endorse this check on my behalf.

Authorizations will be honored for 18 months from the date executed. An authorization timely filed will be honored for any hearing, appeal, or reconsideration on the original issue. An authorization shall not continue in effect after said award or awards have been paid.

| Injured worker's signature | Date |
|---|---|
| Sharyl Carter | |

BWC USE

This authorization is not honored by BWC because:

☐ It was not timely filed ☐ It was not properly completed

☐ Other _____

| Claims representative's signature | Office | Date |
|---|---|---|
| | | |

BWC-1360 (Rev. 11/03/2003)
**C-230**

BWC
Ohio Workers' Compensation
Built with you in mind

# First Report of an Injury, Occupational Disease or Death

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

## Injured worker and injury/disease/death info.

Last name, first name, middle initial: CARTER, SHARYL J.
Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Date of birth: 9-1-64
Home mailing address: 92 Woolery Lane #C
Number of dependents:
City: Dayton | State: OH | 9-digit ZIP code: 45415 | Country if different from USA: Mont.
Department name:
Wage rate $ 27.58 ☒ Hour ☐ Month ☒ Week ☐ Year ☐ Other
What days of the week do you usually work? ☒ Sun ☒ Mon ☒ Tues ☒ Wed ☒ Thur ☒ Fri ☒ Sat
Regular work hours: From 2:78 To 4:48
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☒ No If yes, please explain. FRI SAT, SUN
Occupation or job title:
Employer name: Delphi Automotive System
Mailing address (number and street, city or town, state, ZIP code and county): 3535 South Kettering Blvd
Location, if different from mailing address: Moraine OH 45439
Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

| Date of injury/disease | Time of injury ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work ☐ a.m. ☐ p.m. | Date last worked | Date returned to work |
|---|---|---|---|---|---|
| | | | | | |

| Date hired | State where hired | Date employer notified |
|---|---|---|
| | | |

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)

Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

*Benefit application/medical release* – I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological and/or psychiatric information that is causally or historically related to physical or mental injuries relevant to issues necessary to the administration of my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization and any authorized representatives. I further authorize the Ohio Rehabilitation Services Commission to release information about my physical, mental, vocational and social conditions that is causally or historically related to physical or mental injuries relevant to issues necessary for the administration of my workers' compensation claim to the aforementioned parties.

| Injured worker signature | Date | E-mail address | Telephone number ( ) | Work number ( ) |
|---|---|---|---|---|
| Sharyl J. Carter | | | | |

## Treatment info.

| Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date |
|---|---|---|---|
| | | | |

| Street address | City | State | 9-digit ZIP code |
|---|---|---|---|
| | | | |

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No
Is the injury causally related to the industrial incident? ☐ Yes ☐ No

| Health-care provider signature | 11-digit BWC provider number | Date |
|---|---|---|
| | | |

## Employer info.

Employer policy number
Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

| Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number |
|---|---|---|---|---|
| | | | | |

Was employee treated in an emergency room? ☐ Yes ☐ No
Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No
If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

**For self-insuring employers only**
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below.
☐ **Medical only** ☐ **Lost time**

| Employer signature and title | Date | OSHA case number |
|---|---|---|
| | | |

This form meets OSHA 301 requirements

BWC-1101 (Rev. 8/2005)
**FROI-1** (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

OCT 25, 2008

Kearns CO. L PA
Attorney At Law
3028 Victory Parkway
Cincinnati Ohio -45206

Dear Mr. Michael A. Kearns

Enclosed is a copy of a letter I wrote to Mr. Bevon & Associates LPA dismissing, firing that Agency for Representing me on my Workers Compensation Claim No 06-888317. Bevon & Associates Christopher J. Stefanik wrote me an letter stating my claim was denied, dated Oct 20, 2008 I would like for you Mr. Michael A. Kearns to Represent me in my Workers Compensation Claim.

Thank You

Sincerely,

M [illegible] Carter

# BEVAN & ASSOCIATES LPA, INC.

Bevan Professional Building 10360 Northfield Road Northfield, Ohio 44067

THOMAS W. BEVAN
CHRISTOPHER J. STEFANCIK
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JESSICA M. BACON

Akron (330) 650-0088
Cleveland (330) 467-8571
Fax (330) 467-4493
of Counsel
KEITH D. BEVAN

October 20, 2008

Ms. Sharyl Y. Carter
92 Woolery Lane
Apartment C
Dayton Ohio 45415

Re: Claim No. 06-888317
D.O.I. 12-15-2006

Dear Ms. Carter:

Thank you for allowing me to review your Workers' Compensation Claim No. 06-888317. I have examined the documentation in the file including the orders denying your application for workers' compensation benefits. Unfortunately I do not see any opportunity to reverse this denial.

Again, I appreciate you giving me the chance to review this claim and am sorry I could not be of assistance in this case. I would advise that if you are injured on the job in the future to contact an attorney immediately. Proper application preparation and representation at initial hearings is often crucial to obtaining a positive result.

Please feel free to call the office if you have any further questions.

Sincerely,

Christopher J. Stefancik
Attorney at Law for
Bevan & Associates

CJS/sjr